Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHTRUST LLC
PO BOX 890008
HOUSTON TX 77289

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-0334-01

MFDR Date Received
SEPTEMBER 30, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier gave preauthorization for the services performed above based upon the accepted work related injury and the accepted diagnosis code. The carrier forwards these claims to an outside auit company – Universal Smart Comp – for payment of these claims indicating that HealthTrust has a contract with them for a multi-disciplinary chornic pain program. HealthTrust has no contract with USC for this type of program. Sedgwick has already paid for several dates of service, and yet refuses to remit payment for these dates of service."

Amount in Dispute: $9,360.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The disputed billings are being re-audited."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2011 through April 14, 2011	Chronic Pain Management Program	$9,360.00	$4,400.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for payment of Workers' Compensation Specific Services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   EOBs were not presented for review by either party. The health care provider submitted two letters, one each, from Sedgwick CMS and Universal Smart Comp:
   - PROVIDER SEND BACK = PROVIDER HAS MULTIPLE TX ID #'S – TAX ID # ON BILL IS ILLEGIBLE If you believe this is an error please resubmit the document(s) with complete identifying information so it may be correctly matched with a file.
   - Other – USC does not process bills for Chronic Pain Management. Please forward bills for this patient directly to the insurance carrier for processing and payment.

Findings

1. The respondent, in their position summary, dates October 17, 2011, states, "The disputed billings are being re-audited." The Division contacted the requestor July 16, 2012 inquiring as to the payment status. The requestor responded to the request on July 17, 2012 stating, "The October 17, 2011, letter from their attorney indicates that the bills were sent out for re-audit, however, when Universal does not process them, Sedgwick still refuses to handle them directly. Therefore, they never get handled at all. I have repeatedly communicated this error is processing, yet they never seem to understand or care." Therefore, the disputed dates of service will be reviewed in accordance with Division rules and statutes. Per 28 Texas Administrative Code §134.204(h)(1)(B) and (h)(5)(B) reimbursement shall be $125 per hour if the program is CARF accredited. Since HealthTrust did not bill the –CA modifier payment shall be 80 percent of the MAR which is calculated to be $100.00 per hour.
   - March 16, 2011, CPT Code 97799-CP – The health care provider billed 8 hours; the requestor submitted documentation to support 4 hours of the program. As a result, the amount ordered is $400.00.
   - March 21, 2011, March 22, 2011, March 23, 2011, April 12, 2011 and April 14, 2011, CPT Code 97799-CP – The health care provider bill 8 hours per each date of service. Review of the submitted documentation supports the services were rendered as billed. As a result, the amount ordered is $4,000.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ 4,400.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,400.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 22,2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.